to the

House Energy and Commerce Committee
Subcommittee on Health

Presented by

Frank G. Opelka, MD, FACS

RE: Medicare Physician Payments:
How to Build a More Efficient Payment System

November 17, 2005

Statement

of

American College of Surgeons

to
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Chairman Deal, Ranking Member Brown, and distinguished subcommittee members, thank you for the opportunity to testify today on behalf of the 70,000 Fellows of the American College of Surgeons. My name is Frank Opelka. I practice colorectal surgery in New Orleans, and serve as Associate Dean for Healthcare Quality and Safety at Louisiana State University. I also serve as the College's Alternate delegate to the AMA/Specialty Society RVS Update Committee, or "RUC."

We are grateful to you for holding this hearing on the challenges posed by the sustainable growth rate (SGR) method for determining Medicare payments to physicians. While it is important to consider the impact the current system is having in general on physicians and on patient access to care, a wise course for reforming Medicare payment must also consider what is happening across the range of specialties and subspecialties. Spending trends, practices, billing rules,

and the way patient care is delivered all vary substantially among specialties, and the current payment system simply is not designed to accommodate that diversity.

As you are well aware, unless Congress intervenes the current SGR method for determining Medicare physician payments will require a 4.4 percent payment cut in 2006, with an estimated 26 percent cumulative cut anticipated over the next 6 years. As a first step toward bringing some rationality and predictability to the Medicare physician payment system, Congress must act to stop the cut from going into effect on January 1. In the long run, we need a system that enables reimbursements to keep pace with physicians' costs. The SGR system has to be reformed, with future payments linked to a reasonable measure of practice cost inflation such as the Medicare Economic Index.

While these pending cuts threaten the financial viability of physician practices across the range of the specialties, surgeons are uniquely threatened by the current payment system. Policymakers seem to lose sight of the fact that, for many key surgical services, Medicare payments today are about half what they were in the 1980s, even before inflation is taken into account. In addition, as surgeons continue to confront rising practice costs associated with day-to-day operations, they also are faced with some of the highest liability insurance premiums in medicine—a major cost that has escalated in recent years, and one that has not been addressed by the current payment system.

At the same time, by the nature of the services they provide and differences in the way their services are billed, surgeons are less able to compensate for payment losses by increasing the volume of services they provide. For example, patients rarely self-refer to surgeons; rather, most are referred by other physicians who have determined that a surgical assessment is needed. In addition, major operations are reimbursed on a global basis that reflects not only the procedure itself but also the pre- and post-operative care that occurs within a 90-day period. This payment is based on the typical rather than average patient, and remains the same regardless of complications or how many post-operative services an individual requires. Further, unlike most physician services, major procedures can generally be performed only once on a given patient.

As a result, surgery is disproportionately affected by the correlation between the price that Medicare pays for specific physician services and the overall volume target set for all physician services under Medicare. This is because the growth in major operations performed by surgeons is consistently lower than the growth rate for other services provided to Medicare patients. For example, major procedures accounted for 6 percent of total Medicare physician spending in 2004, and for only 3 percent of the growth in Medicare physician spending that year. Practically, this means that the current formula requires

surgeons to bear the cost of increased utilization of services that they do not provide–whether or not that increased utilization is justified.

We did some back-of-the envelope calculations, projecting forward the 2004 growth rates for the major categories of physician services and estimating what surgical services would be paid in the future under a surgery-specific SGR. Under such a system, major operations would be awarded payment increases totaling 14.5 percent by 2011, as opposed to the 26 percent cumulative cut that has been estimated under the current system. Under this scenario most other service categories, of course, would see their cuts deepen over the same period. Clearly, the SGR system is siphoning payments away from surgery toward other services that are experiencing significantly higher rates of growth.

The attached chart compares surgery with the largest category of physician spending—evaluation and management (E/M), or visit services. As you can see, in 1998 Medicare spent about $575 per Medicare beneficiary for visit services; that amount grew by over 36 percent to about $784 in 2003. For major procedures, on the other hand, the comparable figures are $212 in 1998 and $226 in 2003—an increase of less than 7 percent. (I should point out that we expanded the specific services typically classified in the “major procedures” category by Medicare to include several high-volume ambulatory services, including the number one Medicare procedure--cataract surgery.)

We have no reason to suspect that the relatively high rate of spending growth for E/M services is inappropriate. Indeed, it is clear that public health experts and policymakers are very concerned about access to the primary care services that comprise the largest portion of this E/M service category. And, many efforts are underway—including value-based purchasing proposals—that we expect will accelerate the E/M growth rate through improved immunization rates, greater access to screening services, better management of chronic conditions, and so forth. But, what impact will that have on surgery? As the government encourages primary care physicians to provide more of these office-based services, the SGR requires the money to come from other services—regardless of any spending or access issues that may be involved. Surgeons simply cannot continue to foot the bill for increases in the volume of unrelated services provided by others—no matter how valuable those services may be.

In other words, the current Medicare payment and update system is simply inadequate to the task of appropriately pricing services as diverse as E/M and surgery.

With respect to pay for performance or value-based purchasing, the College is optimistic that such a program, if properly designed, holds great promise for truly imposing some rationality on the physician payment system. We agree that it is time to shift the focus away from the “price” Medicare pays for a service and toward the “effectiveness” of the care that patients receive.

Since the College's founding over 90 years ago, it has demonstrated its commitment to ensuring high-quality surgical care for patients. This commitment to excellence in surgery is evident in the professional standards to which our Fellows are held and in the wide range of educational services that the College offers to ensure that they maintain their skills and learn about advances in technology and practice. We set standards for trauma care, we approve hospital cancer programs, and we have developed standards for bariatric surgery programs. With respect to promoting processes and data collection to improve surgical outcomes, the College has partnered with CMS and the Centers for Disease Control and Prevention in the Surgical Care Improvement Project (SCIP), and first with the Department of Veterans Affairs and now with hospitals and health plans in the National Surgical Quality Improvement Project (NSQIP). The College believes strongly that, if value-based purchasing in Medicare is to be successful, physician measures must be based on physician-led efforts such as these public-private partnerships, which have been shown to improve outcomes for patients and lower healthcare costs.

Again, it is important to note that the diversity of physician services and the settings in which they occur must be taken into account in the design of a value-based purchasing program. Surgeon-led quality improvement initiatives, for example, tend to focus on the entire episode of care and the system in which patient care is provided. Surgery is a team effort, and our quality and safety

efforts incorporate all elements of that team. This is a very different approach from the more narrowly drawn process measures that have been developed for other service types. Surgical care also lends itself more readily to risk-adjusted outcomes measurement than many primary care services for which success relies more heavily on patient compliance factors beyond the physician's control. Finally, the potential for cost savings through improvements in the quality of surgical care can be tremendous. For example, it has been estimated that taking the necessary steps to prevent post-operative pneumonia can save $22,000 to $28,000 per patient admission. However, for Medicare these savings are achieved outside the Part B physician payment system, a complex issue that needs to be addressed if payment incentives are to truly be aligned to favor cost effectiveness and quality improvement.

Nevertheless, the College and its Fellows stand ready to work with Congress and with CMS to ensure that any value-based purchasing reforms are structured in such a way to properly reward high-quality care and to promote advances that will improve the quality of surgical care in the future.

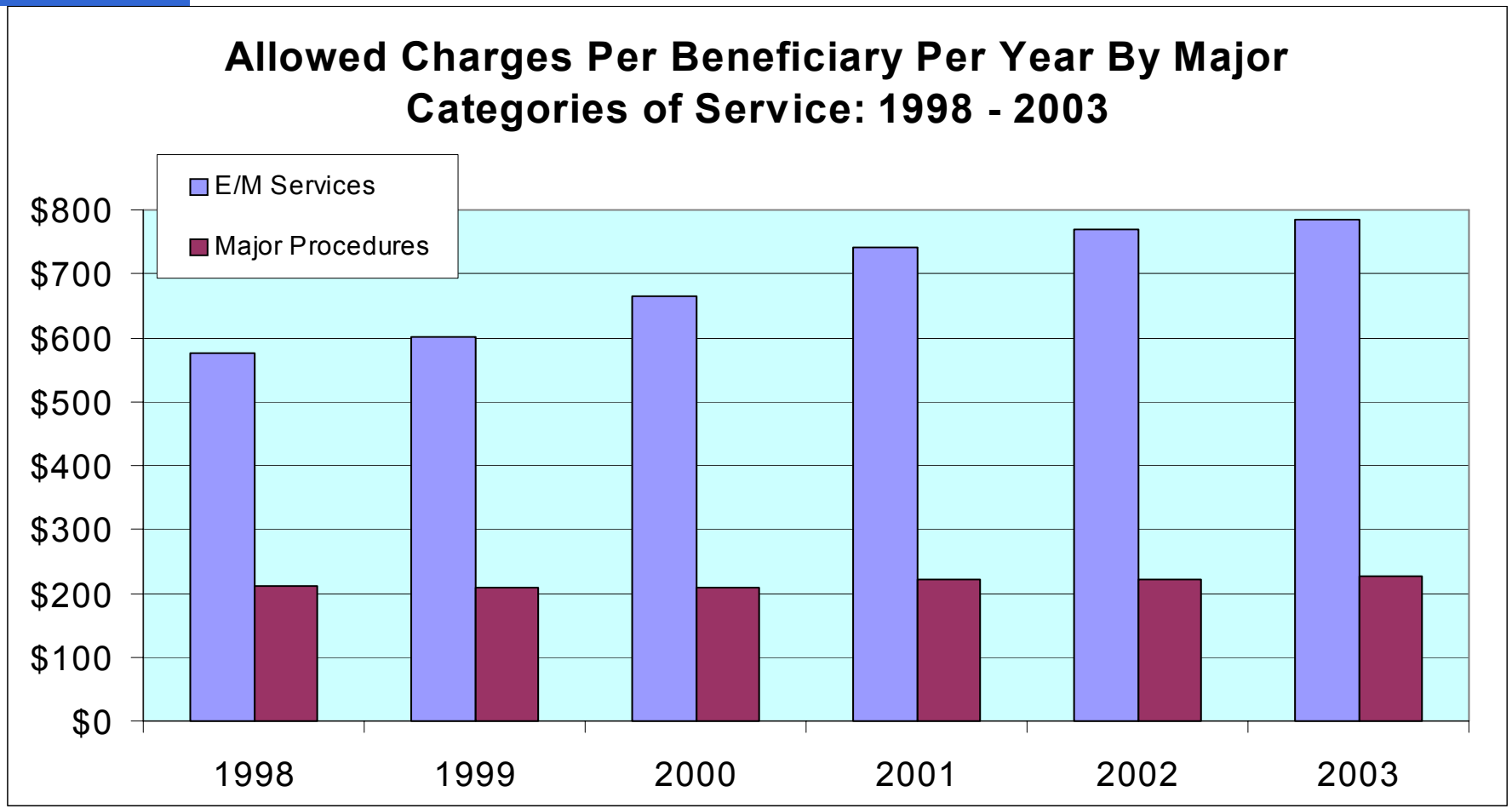
Finally, with respect to the reconciliation process, we note that the Senate's package (S. 1932) proposes to replace the 4.4 percent cut in 2006 with a 1 percent payment increase. While we certainly appreciate this effort at a time when the committee was seeking budget savings, we are deeply concerned that the value-based purchasing program included in the bill is unworkable and holds the potential of causing even greater financial instability. Value-based

purchasing simply cannot succeed in a system that is producing steep, annual payment cuts. By-and-large, physician offices are small businesses—the majority of surgeons are in solo practice or in groups of two or three partners. They need a reasonably stable and predictable revenue stream to make effective practice decisions.

When a conference committee convenes, members of this Subcommittee will be asked to help draft revisions and ultimately vote on value-based purchasing provisions. In that effort, we ask that you be mindful of the commitment that will be required by both physicians and the government to truly align incentives and make value-based purchasing work toward achieving the goal of higher-quality patient care.

Mr. Chairman, the College appreciates this opportunity to share its perspective on the challenges facing surgeons under the Medicare program today. We are ready to work with you to reform the Medicare physician payment system to ensure that our patients have access to the high-quality surgical care they need.

Where is the Growth?



ACS analysis of BETOS data files 1998 to 2003